North Carolina Industrial Commission

IC File #_____

Emp. Code #_____

Carrier Code # _____

Employer FEIN _____

The I.C. File # is the unique identifier for this injury. It will be provided by return letter and is to be referenced in all future correspondence. Code numbers assigned to each employer and carrier should be inserted before mailing.

SUPPLEMENTAL REPORT FOR FATAL ACCIDENTS

(FORM 19, EMPLOYER'S REPORT OF EMPLOYEE'S INJURY TO THE INDUSTRIAL COMMISSION, MUST ALSO BE SUBMITTED IN EVERY CASE)

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act

Deceased Employee's Name	Employer's Name ( ) Telephone Number
Address	Employer's Address City State Zip
City State Zip	Insurance Carrier
( ) ( )	Carrier's Address City State Zip
Home Telephone Work Telephone	( ) ( )
☐ M ☐ F / /	Carrier's Telephone Number Fax Number
Social Security Number Sex Date of Birth	

1. Date of accident: _____ 2. Date of death: _____, 20 ____

3. Dependents, or if employee left no dependents, next of kin: (Indicate which are non-resident aliens)

	Name	Date of Birth	Relationship	Present Address
a.				
b.				
c.				
d.				
e.				
f.				

4. Immediate cause of death: _____

_____

5. Amount of burial expenses authorized $ _____

_____
Signature of Employer or Carrier/Administrator Title Date

MAIL TO:

NCIC - CLAIMS SECTION
4335 MAIL SERVICE CENTER
RALEIGH, NC 27699-4335
MAIN TELEPHONE: (919) 807-2500
OMBUDSMAN: (800) 688-8349

FORM 29